

<i>SERFF Tracking Number:</i>	<i>UHLC-126906398</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unimerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>47322</i>
<i>Company Tracking Number:</i>	<i>UMERAPP (02/02)-1</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Stop Loss</i>		
<i>Project Name/Number:</i>	<i>Schedule and Application/</i>		

Filing at a Glance

Company: Unimerica Insurance Company

Product Name: Stop Loss

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.004 Self-Funded Health Plan

Filing Type: Form

SERFF Tr Num: UHLC-126906398 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 47322

Co Tr Num: UMERAPP (02/02)-1

State Status: Approved-Closed

Authors: Jayne Jackowski, Lynn
Kaisershot

Reviewer(s): Rosalind Minor

Disposition Date: 11/22/2010

Date Submitted: 11/16/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Schedule and Application

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/22/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 11/22/2010

Created By: Jayne Jackowski

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jayne Jackowski

Filing Description:

We respectfully submit the proposed Stop Loss forms for your approval. These are new forms and are not intended to replace any forms previously filed with the Department.

These forms will be used with previously approved forms to insure individual employers who self-insure their employee health benefits against specific and/or aggregate excess losses. The previous policy form number is UMEREL (02/02) and was approved by your office on April 29, 2002.

Certain provisions have been [bracketed] to indicate they are variable and other provisions have been {bracketed} to

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indicate they are variable by omission. You have our assurance that only variable areas will be changed and or omitted.

Company and Contact

Filing Contact Information

Jayne Jackowski, Senior Specialty Product Analyst
Jayne.Jackowski@eams.com
3100 AMS Blvd.
920-661-2234 [Phone]
8002325432 [Ext]
Green Bay, WI 54313
920-661-9861 [FAX]

Filing Company Information

Unimerica Insurance Company
PO Box 150450
Hartford, CT 0606115-0450
(860) 702-6017 ext. [Phone]
CoCode: 91529
Group Code: 707
Group Name:
FEIN Number: 52-1996029
State of Domicile: Wisconsin
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unimerica Insurance Company	\$50.00	11/16/2010	41948565
Unimerica Insurance Company	\$50.00	11/19/2010	42148185

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/22/2010	11/22/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/19/2010	11/19/2010	Jayne Jackowski	11/19/2010	11/19/2010

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<i>Product Name:</i>	<i>Stop Loss</i>		
<i>Project Name/Number:</i>	<i>Schedule and Application/</i>		

Disposition

Disposition Date: 11/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Stop Loss Application	Approved-Closed	Yes
Form	Policy Schedule	Approved-Closed	Yes

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Product Name: Stop Loss
Project Name/Number: Schedule and Application/

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/19/2010

Submitted Date 11/19/2010

Respond By Date

Dear Jayne Jackowski,

This will acknowledge receipt of the captioned filing.

Objection 1

- Stop Loss Application, UMERAPP (02/02)-1 (Form)
- Policy Schedule, UMEREL (02/02) SCHED (Form)

Comment: Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Company Tracking Number: UMERAPP (02/02)-1
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.004 Self-Funded Health Plan
Product Name: Stop Loss
Project Name/Number: Schedule and Application/

Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/19/2010
Submitted Date 11/19/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: Additional filing fee has been sent.

Related Objection 1

Applies To:

- Stop Loss Application, UMERAPP (02/02)-1 (Form)
- Policy Schedule, UMEREL (02/02) SCHED (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

Jayne Jackowski, Lynn Kaisershot

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Form Schedule

Lead Form Number: UMERAPP (02/02)-1

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/22/2010	UMERAPP (02/02)-1	Application/ Stop Loss Enrollment Form	Application	Initial			UIC Stop Loss app-UMERAPP_02.02_-1.pdf
Approved-Closed 11/22/2010	UMEREL (02/02)	Schedule Pages	Policy Schedule	Initial			UIC Policy Schedule amendment.pdf

UNIMERICA INSURANCE COMPANY

A Stock Company

Administrative Offices: [6300 Olson Memorial Highway, Golden Valley, MN 55427]

Phone: 1-800-454-0233]

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Unimerica Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: [ABC Company]

Address: (street, city, state, and zip): [1234 Any Street, Any City, USA]

Key Contact: [John Doe]

Telephone: [123-456-6789]

Tax ID: [123456]

Applicant is a: ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ Proprietorship ☐ Other:

Nature of Business of the Group to be Insured: [Banking] **Requested Effective Date:** [1/1/2002]

Total number of eligible persons: [Employees: 150 Retirees: 0]

Are retirees covered: ☐ Yes ☐ No.

Affiliates or Subsidiaries:

Addresses of Affiliates or Subsidiaries:

[Full Name of Administrator: ABC Third Party]

[Address: _____ (street, city, state, and zip): _____]

[Key Contact: _____ Telephone: _____]

[Agent or Broker: Jane Does]

[Tax ID: 123-66-6789]

[Address: 1234 Any Street, Any City, USA]

SPECIFIC EXCESS LOSS INSURANCE:

☐ YES

☐ NO

Benefit Period: [Covered Expenses Incurred from _____ through _____ and
Paid from _____ through _____.]

[If this Policy has a Subsequent Policy Period, the Benefit Period is changed to:

Covered Expenses Incurred from _____ through _____ and Paid from _____ through _____ ;or, through any termination within the
next Benefit Period, whichever is earlier.]

[Covered Expenses Incurred from _____ through _____ will be limited to _____ per Covered Person.]

Specific Deductible per [☐ Covered Person {☐ family}: \$ _____]

Specific Percentage Reimbursable: [_____]

Maximum Specific Benefit per [☐ Covered Person {☐ family}: \$☐ Unlimited ☐ Other \$ _____]

Covered Expenses Under Specific Excess Loss: [☐ Medical ☐ Stand Alone Prescription Drug Program]

{{Common Accident Provision: ☐ Yes ☐ No}}

Description:	Rates: {the rates below will increase by ₃ [5%]- if the Access To ₄ [OptumHealth Care Solutions] Agreement is not signed}
[Employee	\$ _____
	\$ _____
	\$ _____
	\$ _____]

{Minimum Specific Premium \$ _____}

[[1. Specific Accommodation Reimbursement Endorsement ☐ Yes ☐ No

2. Specific Step-Down Deductible Endorsement ☐ Yes ☐ No

3. Specific Terminal Liability Endorsement ☐ Yes ☐ No

4. Aggregating Specific Deductible Endorsement ☐ Yes ☐ No]}]

☐ **NO**

Covered Expenses Incurred from 10/1/2001 through 12/31/2001 will be limited to 15% of the Annual Aggregate Deductible.]

☒ Medical ☐ Dental ☐ Vision
☒ Stand Alone Prescription Drug Program
☐ Other (Please Specify)]

Maximum Aggregate Benefit: ☐ \$500,000 ☒ \$1,000,000 ☐ Other \$ _____

Minimum Annual Aggregate Deductible: $\frac{1}{12}$ [\$123,000 or 100% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.]

[Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: [\$

Aggregate Excess Loss Premium: \$10.00 per employee per month]

{Aggregate Terminal Liability Endorsement: ☒ **Yes** ☐ **No** [☒ **Monthly** ☐ **Annually** **\$.65 per employee**]

{Aggregate Accommodation Endorsement: ☒ Yes ☐ No [☒ Monthly ☐ Annually \$1.00 per employee]}

Monthly Aggregator Factors:[
Covered Persons	Medical	Prescription Drugs	Dental	Vision	
Employee					
					1

It is understood and agreed by the undersigned that:

- a. The statements, declarations, and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.
- b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document [within 90 days] after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document [within 90 days], the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.
- c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.
- d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.
- e. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.
- f. {The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administrator are binding on the undersigned. }

- g. [Other: {The undersigned Employer understands the rates for Specific Excess Loss Benefits includes the use [OptumHealth Care Solutions Network] and has signed the Access To Transplant Services Agreement. If the Access To Transplant Services Agreement is not signed and attached to this application, the rates for Specific Excess Loss Benefits will be increased by [5%-15%].}]
- h. Other: []

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: _____

Signature of Authorized Person: _____

Print Name: _____ Title: _____

Date: _____

Signature of Agent or Broker: _____

Print Name of Agent or Broker: _____

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Arkansas and Louisiana and Rhode Island:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:

It is a crime to knowingly provided false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Unimerica Insurance Company

A Stock Company

[Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343

Phone: 1-800-454-0233]

SCHEDULE OF BENEFITS

[This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: ABC Company, Inc.
Policy Number: 12345
{Original} Effective Date: _____
{Subsequent Policy Period Effective Date: _____}
Administrator: _____

Coverage specified herein is applicable only during the Policy Period from 1/01/01/01 to 12/31/01, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE (X) Yes () No

Benefit Period: [Covered Expenses Incurred from 10/01/00 through 12/31/01 and Paid from 01/01/01 through 12/31/01.

[If this Policy has a Subsequent Policy Period, the Benefit Period is changed to:

Covered Expenses Incurred from _____ through _____ and Paid from _____ through _____; or, through any termination within the next Benefit Period, whichever is earlier.]

Covered Expenses Incurred from 10/1/00 through 12/31/2000 will be limited to \$50,000 per Covered Person.]

Specific Deductible per [(X) Covered Person {() family }] \$ 25,000

Specific Percentage Reimbursable [100 %]

Maximum Specific Benefit per [(X) Covered Person {() family}] ☐ Unlimited ☐ Other \$ _____]

Specific Excess Loss Insurance includes:

[() Medical (X) Stand Alone Prescription Drug Program]

[[Common Accident Provision: () Yes (X) No]]

[[Common Accident means if more than one Covered Person in the same immediate family incurs Covered Expenses as a result of the same accident, the Specific Deductible will be applied only once to all Covered Expenses Paid because of that accident for all Covered Persons in the family during the same Benefit Period.]]

[Description	Rates
Employee	\$ _____
Family	\$ _____
	\$ _____
	\$ _____

{[Specific Accommodation Reimbursement Endorsement ☐ Yes ☐ No _____
Specific Terminal Liability Endorsement ☐ Yes ☐ No _____
Aggregating Specific Deductible Endorsement ☐ Yes ☐ No \$ _____
Specific Step-Down Deductible Endorsement ☐ Yes ☐ No _____]}

AGGREGATE EXCESS LOSS INSURANCE (X) Yes () No

Benefit Period: [Covered Expenses Incurred from 10/01/00 through 12/31/01,
and Paid from 01/01/01 through 12/31/01.

Covered Expenses Incurred from 10/1/2000 through 12/31/2000 will be limited to 15% of the Annual Aggregate Deductible.]

Aggregate Excess Loss Insurance includes:

(X) Medical (X) Stand Alone Prescription Drug Program () Dental Care
() Vision Care () Weekly (Disability) Income [() Other _____]

Aggregate Percentage Reimbursable [100 %]

Maximum Aggregate Benefit: [\$ 1,000,000]

Minimum Annual Aggregate Deductible ₂ [\$ N/A or 100 % of the first Monthly Aggregate Deductible amount times 12, whichever is greater.]

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: [\$ _____]

Monthly Aggregate Factors[
Description	Medical	Prescription Drugs	Dental	Vision	Weekly Income	Other
Employee	\$					
	\$					
]

Aggregate Excess Loss Premium [(X) \$ _____ per [Employee] per month () annual \$ 400].

{ Aggregate Terminal Liability Endorsement Premium: [\$.65 per Employee per month] }

{ Aggregate Terminal Liability Endorsement Monthly Factors: [xxxx] }

{ Aggregate Accommodation Endorsement Premium: [\$ _____] }

SPECIAL CONDITIONS:

[_____]

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Supporting Document Schedules

		Item Status:	Status
			Date:
Bypassed - Item:	Application	Approved-Closed	11/22/2010
Bypass Reason:	See Form Schedule		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	11/22/2010
Bypass Reason:	NA-Schedule and Application		
Comments:			